

INCIDENT FACTS

REPORT #:

71-244-2023

REPORT DATE:

August 28, 2023

INCIDENT DATE:

May 31, 2022

WORKER:

59 years old

INDUSTRY:

Property Managers /
Building Construction

OCCUPATION:

Construction Foreman

SCENE:

Commercial construction site

EVENT TYPE:

Fall from leading edge



Fall protection anchor, shock-absorbing lanyard, and lifeline near leading edge where worker fell.

[For a slideshow version, click here.](#)



This narrative was developed to alert employers and workers of a tragic incident and is based on preliminary data ONLY and does not represent final determinations regarding the nature of the incident or the cause of the injury. Developed by WA State Fatality Assessment and Control Evaluation (WA FACE) and the Division of Occupational Safety and Health (DOSH), WA State Dept. of Labor & Industries. WA FACE is supported in part by a grant from the National Institute for Occupational Safety and Health (NIOSH grant# 5U60OH008487). For more information visit www.lni.wa.gov/safety-health/safety-research/ongoing-projects/work-related-fatalities-face.

Foreman Falls 17 Feet from Leading Edge of Roof Deck

SUMMARY

A 59-year-old construction foreman died after falling from the leading edge of a roof deck. He worked for his employer, a residential and commercial property management company, for eight months. His duties included leading work crews, basic carpentry, framing, sheeting, and siding.

The foreman had been at the construction site of a new single-story commercial building for almost a month. On the incident day, he was alone on top of the building constructing a plywood roof deck. He was using a personal fall arrest system (PFAS), including anchorage, lifeline, rope grab, body harness, and shock-absorbing lanyard. A framing helper was assisting from the ground by using a scissor lift to hand him tools and materials.

The foreman was laying plywood sheets onto trusses that had brackets on each receiving end where the sheets would be set. He was using his heel to kick the sheets into the brackets. When he tried moving a sheet with his feet, it gave way and dropped under his weight. He fell 17 feet to the ground inside the building with the sheet landing beside him. The helper was outside the building and did not see the fall. A manager watching live-streamed job site surveillance video in the office saw the worker on the ground, had the helper check him, and called 911. He died at the hospital after six days on life-support.

Following the incident, investigators found:

- The worker's PFAS was in excess of 50 feet for a 17-foot fall. An unnecessary second shock-absorbing lanyard was connected to the anchorage. His chest strap was not connected and the leg straps were loose. If the worker had the correct fall distance needed for his PFAS to engage and arrest his fall, it is likely his body still would have slipped out of the harness.
- The employer did not provide adequate fall protection training, specifically:
 - How to evaluate the fall clearance needed in order to select, install and use an appropriate PFAS.
 - How to engage all connectors to ensure the worker stays fully secured in the harness during a fall.

REQUIREMENTS

Employers must:

- Employers with employees exposed to fall hazards must have policies in their accident prevention program (APP) that meet the Unified Safety Standards for Fall Protection. See [WAC 296-880](#)
- Ensure that a fall arrest system, fall restraint system, or positioning device system is provided, installed, and implemented in accordance with [WAC 296-880-400 Fall protection system specifications](#) when employees are exposed to fall hazards of six feet or more to the ground or lower level while constructing a leading edge. See [WAC 296-880-30005\(1\)\(b\)](#)
- Ensure a competent person trains each affected employee to know at least the following:
 - (a) The nature of fall hazards in the work area; (b) When fall protection is required; (c) What fall protection is required; (d) The correct procedures for erecting, maintaining, assembling, disassembling, and inspecting the fall protection systems to be used; (e) The use and operation of fall protection systems used; (f) Limitations of fall protection systems used; (g) Proper care, maintenance, useful life, removal from service; and (h) The requirements of this chapter. See [WAC 286-880-10015\(2\)](#)

RECOMMENDATIONS

FACE investigators concluded that to help prevent similar occurrences employers should:

- Discuss fall protection policies at crew meetings, monthly safety meetings, and annual stand-downs.
- Provide recurring hands-on fall protection training and evaluate workers' ability to use it correctly.

RESOURCES

[Fall Protection Fundamentals online training course](#) - Oregon OSHA Public Education [Spanish version](#)



Lifeline with rope grab stretched to show excess length from worker's fall location (x).